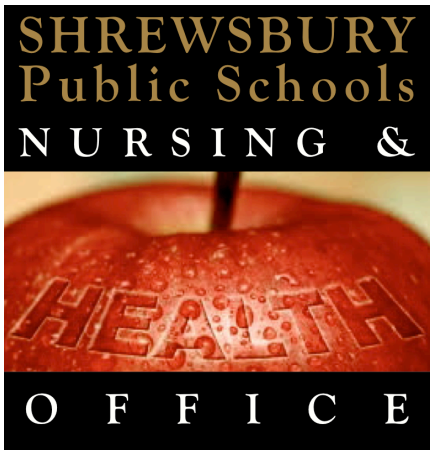

Allergy Emergency Action Plan

Below you will find an "Allergy Emergency Action Plan." We ask that you and your child's physician complete and sign this annual form so that we will have permission to treat your child in the event of a life-threatening allergic reaction. This form will ask for the most current information regarding your child's allergy and contact information.

The Shrewsbury Public Schools District is registered with the Massachusetts Department of Public Health "to permit unlicensed, properly trained school personnel, (teachers, para-professionals, extended school care staff, bus drivers) to administer epinephrine by auto injector to students with a diagnosed life-threatening allergic condition when a school nurse (RN) is not immediately available". We **cannot delegate Twinject™** administration to non-nurses as the second dose is not by auto injector. **School nurses cannot delegate prn** (as needed) **medications including antihistamines**, such as Benadryl, to unlicensed personnel (Board of Registration in Nursing, 244 CMR 3.05). Therefore, if the prescribed treatment of your child's life-threatening allergy includes an antihistamine, only an EpiPen® will be administered on **field trips** or any other occasion when the school nurse is not available.

This form and an updated EpiPen® should be submitted on or before the first day of school. If possible check with your pharmacist to request a pen that will not expire before the end of the school year.

Thank you for your time and cooperation in this matter. We look forward to working with you to keep your child safe. If you should have any questions, please call your school nurse directly.

Respectfully,

The Shrewsbury Public School Nurses

Shrewsbury Public Schools
Allergy Emergency Action Plan

Student Name: _____ D.O.B.: _____ Photo:

ALLERGY TO: _____

ASTHMATIC: YES* ☐ **HIGH RISK FOR SEVERE REACTION** NO ☐

◆STEP 1: TREATMENT◆

If a food allergen has been ingested, but no *symptoms* call family immediately to remove child from activity or seek medical attention other than 911.

Symptoms: (To be determined by physician authorizing)		**Give Checked Medication**	
Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
Throat*	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
Lung*	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
Heart*	Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine

*** If student presents with life-threatening symptoms, the EpiPen® will be given, and 911 will be called. The severity of symptoms can change quickly and become potentially life threatening.**

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr.

Antihistamine: Give: _____
Medication ~ Dose ~ Route

Other: Give: _____
Medication ~ Dose ~ Route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in treatment for anaphylaxis.

◆STEP 2: TREATMENT◆

1. Call 911/EMS: State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr.: _____ Phone: _____

3. Parent: _____ Phone(s) day: _____

4. Parent: _____ Phone(s) day: _____

5. Emergency Contacts:
Name/Relationship Phone Numbers – best to reach during school hours:

a. _____ _____ _____

Parent/Guardian Signature: _____ **Date:** _____
By signing this, you are giving permission for the school nurse/personnel to contact the prescriber to clarify orders or to discuss concerns related to the treatment of your child.

Doctor's Name: _____ **Date:** _____

Doctor's Signature: _____*****Continued on next page**

Student Name: _____ **Date of Birth:** _____

INDIVIDUAL CONSIDERATIONS

Please list any accommodations or additional information that will assist in the care of your child:

_____
__

_____
__.

SELF-MEDICATION– for School Age/Youth:

☐ **YES**, Student can self-medicate. I have instructed _____ in the proper way to use his/her medication. It is my professional opinion that he/she **SHOULD** be allowed to carry and self-administer his/her medication. Student has been instructed not to share medications. Should the student violate these restrictions, the privilege of self-medicating will be revoked, student's parent/guardian will be notified, and disciplinary action may be taken per schools' policy. Students are required to notify the nurse when carrying inhalers, insulin and EpiPens.

☐ **NO**, It is my professional opinion that _____ **SHOULD NOT** carry or self-administer his/her medication.

☐ **YES**, this child can and will carry their EpiPen in their backpack or on their person.

FIELD TRIP PROCEDURES:

Rescue meds should accompany child during any off-site activities. Staff members attending the field trip must be trained regarding rescue medication use.

The child should remain with staff or parent/guardian during the entire field trip. YES ☐ NO ☐

Parent/Guardian Signature: _____ **Date:** _____

Doctor's Signature: _____ **Date:** _____

EXTENDED DAY PROGRAMMING:

☐ **Yes,** Student attends Extended Day at Shrewsbury Public Schools.

☐ **No,** Student does not attend Extended Day at Shrewsbury Public Schools.

1. If an antihistamine needs to be administered, the parents will be called to pick up their child.
2. Extended day staff will remain with student until parent arrives or other emergency interventions are required.

Parent/Guardian Signature: _____ **Date:**_____

Doctor's Signature: _____ **Date:** _____

Bus – The transportation company should be alerted to child's allergy by the parent/guardian.